Child Safeguarding Practice Review:
BSCP 2020-21/01

Report Author: Beverley McConnell

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1. Overview

1.1 In August 2020 the Birmingham Safeguarding Children Partnership (BSCP) commissioned a *Local Child Safeguarding Practice Review (LCSPR)* to examine multi-agency practice and identify potential areas for improvement in how agencies work together to safeguard new-born babies, particularly during the Covid-19 national lockdown. The agencies included in the review are listed in the *Glossary of Agencies and Terms.*

1.2 The review examines the contact and involvement of agencies and professionals with a one-month-old baby of White British cultural heritage and the baby's parents. Agencies were involved soon after the baby's birth when there was a witnessed episode of domestic abuse at the hospital. At a few weeks of age, the baby suffered serious head injuries and bruising to the body. The medical view was that these injuries were likely to be non-accidental, and possibly as a result of a shaking incident. During the course of the review West Midlands Police (WMP) were undertaking a criminal investigation into how the injuries to the baby were sustained, and both parents were arrested and charged.

1.3 Following a criminal trial both parents were found guilty of causing or allowing serious physical harm to a child. The baby's father was sentenced to five years for causing the serious injuries to the baby, while his mother was given a two-year suspended sentence as she had 'failed to take reasonable steps to protect her son'.

1.4 During the course of this review the baby has made a good recovery and while it is not known if there will be any long-lasting impact from their injuries they have remained in a safe and appropriate placement since their injuries came to light.

Executive Summary

1.5 The executive summary provides a brief overview of the review findings; what went well, what we've learnt and why these issues persist.

What have we learnt?

1.6 In examining the involvement of agencies with the baby, the review identified practice and systems issues that impacted on practitioners' understanding of possible risks to the baby and the effectiveness of their multiagency response. These are:

- Although a parental history of domestic abuse, low mood, poor emotional regulation, learning disability and neurodiversity was recorded, these factors were not considered in assessments and did not take into account the level of possible risk or unmet need.
- There was insufficient consideration of how these factors might impact on the parenting ability of relatively young, new parents, and the support they may require.
- Practitioners' responses were influenced by their acceptance of mother's assurances and minimisation of domestic abuse and a focus on erroneous referral

information which obscured the primary factor of witnessed domestic abuse following birth, so that decision making and actions taken did not take account of the possible risk to the baby and mother.

- The practitioners did not consider whether there was a need for assessment of the father under the Care Act 2014, to offer support for his mental health and learning disability, and how potential paternal risk and vulnerability factors could be supported using a Think Family approach.
- The parents attended different GP practices which meant their health information could not be seen by the other parent's GP which led to gaps in knowledge. Women are linked to their children through maternity records however this is not the case for fathers or other male partners which is a national issue.
- Practitioners' attempts to escalate referrals stalled and professional differences were unresolved.

1.7 Several of these issues particularly around pre-birth assessment and effective engagement with fathers have previously been highlighted in National Reviews[1] and locally in a BSCP review of a six-and-a-half-month-old child in 2020. The BCT Ofsted focussed visit, conducted 19 February 2020[2], also notes issues with the quality of information within partners referrals.

What went well?

1.8 There were several examples of good practice, including:

- The Community Midwifery Team took a detailed booking history from the mother and had regular face to face contact throughout pregnancy and after the baby's birth, despite Covid restrictions.
- Referrals to the Children's Advice and Support Service (CASS) from Birmingham Women's Hospital (BWH) and West Midland Police (WMP) regarding domestic abuse following birth were timely and clear regarding the perceived risks and inherent vulnerability of the baby as a new-born infant.
- The Police referral was screened within 24 hours by a CASS practice supervisor who recognised the domestic abuse and determined the concerns were '*complex and significant*' and that further social work oversight was required in line with expected practice.
- There was evidence of some professional challenge around the risks of domestic abuse by BWH and WMP who sought to progress the referral to the Multi-Agency Safeguarding Hub (MASH) through the escalation protocol. The MASH Safeguarding nurse recognised incorrect information was included in the referral and this was appropriately escalated.
- The Health Visitor quickly identified the need to prioritise a new birth visit for the baby on receipt of the outcome form from CASS.

[1] https://www.gov.uk/government/publications/safeguarding-children-under-1-year-old-from-non-accidental-injury
[2] BCT Ofsted Focussed Visit

Why do these issues persist?

1.9 While it is recognised that '*protecting an unborn baby from abuse and neglect presents particular challenges for professionals due to the uncertainties about appraising future harm and functioning of family relationships'* the review found that the services provided to the baby were not all as robust, coordinated or effective as they needed to be, when considered against expected practice standards.

1.10 The provision of services and response to the safeguarding referral to CASS was impacted by incorrect information becoming the focus for the response. The application of thresholds in the assessment, decision-making and level of support offered to the baby were not consistent with the degree of possible risk and inherent vulnerability of the baby as set out in the threshold document[3].

1.11 Human factors around *'confirmation bias'* hindered the judgements made and actions taken. The original focus of the referral of postnatal domestic abuse, witnessed by professionals, and concerns regarding coercive control became obscured and the response was downgraded from child protection to Child in Need, and then to Universal Plus. As there was no strategy discussion this was a single agency decision.

1.12 During the course of the review practitioners raised concerns regarding the volume of referrals into CASS and their capacity to progress them thoroughly in a timely way. This was said to reduce opportunities for reflection and to check analysis before outcomes were agreed. Assurances have been provided to the review that caseloads are regularly reviewed and the CASS processes had been strengthened following their Ofsted focussed visit, February 2020.

1.13 There were gaps in the information known by practitioners, in part because the CASS screening did not include lateral checks to GPs for adults, which could have identified significant information about the baby's parents. MASH health practitioners had limited access to the mother's GP records through Your Care Connect but it was not accessed at the time as the case was stepped down from section 47[4] to Early Help. Shared Care Records[5] were not available to health practitioners at the time but have been utilised subsequently and also now provide access to the father's GP record.

1.14 There were practice issues that presented due to Covid-19 visiting restrictions both at the hospital and at home. During the mother's pregnancy, although a visit had been planned a telephone call was made at 36 weeks + 4 days. As there were other people heard on the call the routine question regarding domestic abuse was not asked. Police staff would have spoken to the mother on the ward themselves regarding the witnessed domestic abuse incident, instead of ward staff asking her about it, and then considered next steps required and interviewed the father.

[3] Right_Help_Right_Time_Guidance_Dec_2021_002.pdf (lscpbirmingham.org.uk)
[4] https://www.legislation.gov.uk/ukpga/1989/41/section/47
[5] https://www.england.nhs.uk/digitaltechnology/connecteddigitalsystems/shared-care-records/

1.15 The BSCP has a robust, well-defined escalation protocol that practitioners were aware of, however, attempts to escalate this case stalled and professional differences around outcomes remained unresolved when the baby sustained the serious injuries. The health practitioners were clear in their escalations that the initial focus of domestic abuse had been obscured by the incorrect information of children previously being removed and the case had been stepped down without a strategy discussion. Had the escalation been resolved sooner, section 47 enquiries could have resulted in robust safety planning.

What needed to change?

1.16 At the time of writing the review the Partnership were asked to consider making the following system improvements where there are multiple known parental vulnerabilities and actions were undertaken around the following areas of practice:

- MASH Health practitioners should be able to access both parents' GP health information when screening referrals to enable relevant information being considered.
- Strengthen the engagement, referral and assessment of fathers during pregnancy and infancy.
- Improve the response to parental conflict, coercive control and domestic abuse in pregnancy and infancy to ensure consistent agency responses to domestic abuse (including practitioner understanding and application of the Domestic Abuse, Stalking & Honour-based violence (DASH) risk assessment).
- Ensure assessment and increased support for parents where parental neurodiversity, learning disability and emotional dysregulation may impact on parental capacity using a 'Think Family' approach, through appropriate policies, procedures and training provision
- Strengthen practitioner understanding of the effect of adverse childhood experiences on parenting ability and use of trauma informed approaches in interventions.
- Enhance practitioners' understanding of confirmation bias[6] as well as their application of professional curiosity.
- Ensure key messages about the timeliness of information seeking and sharing, accuracy of information in referrals and understanding of parental history is embedded in practice.
- Explore whether there is any evidence of a lack of capacity within CASS to progress referrals effectively and to make the necessary lateral checks.

2. Methodology

2.1 *Working Together to Safeguarding Children (2018)* and its successor *Working Together to Safeguarding Children (2023)* requires that the safeguarding partners are responsible for commissioning and supervising reviewers for local reviews. As such this

[6] RR337 - Clinical Judgement and Decision-Making in Childrens Social Work.pdf (publishing.service.gov.uk)

report has been quality assured by the partnership Review Team and agreed by the safeguarding partners.

2.2 The review is written in line with expectations within practice guidance [7] that LCSPRs are designed to add reflection and learning into local safeguarding systems and that the report '*must focus on... why do these themes keep recurring and what can be done to address them?*'. The findings and learning points therefore focus on systems learning, typicality and appraisal of practice and what has been done to address these and what further improvements are required to strengthen the safeguarding system in Birmingham.

2.3 The review considered agency involvement with the family during the pregnancy, around the birth and until the discovery of the baby's serious injuries. Relevant parental history and agency involvement prior to the pregnancy is summarised in the relevant key practice episodes.

Family Composition and Contribution

2.4 The family members referenced in the review are:

- Subject Child: the baby – aged one month at the time of the incident
- Mother: aged 19 at the time of the incident
- Father: aged 24 at the time of the incident

2.5 Due to the parallel proceedings in place, the lead reviewer was unable to speak with the parents during the course of this review. Parents were informed when the review began and following the criminal proceedings, the mother, father and maternal family members were offered the opportunity to contribute to the review. The baby's father declined, and the mother and her family members did not respond.

2.6 While the baby is not able to offer a voice, the baby is said to be recovering well from the injuries, developing as expected and is in an appropriate placement. It is not yet known whether their early lived experiences will have a lasting impact on the baby's future health and wellbeing.

Review approach

2.7 The review explored the quality and effectiveness of the multi-agency safeguarding response to unborn babies where there are indicators of risk such as domestic abuse, paternal neurodiversity with poor emotional regulation and maternal low mood. The approach combined early analysis from the Rapid Review and information reports. Prior to a collective learning workshop, practitioners were requested to complete reflective workbooks to consider areas of good practice as well as their immediate learning. There were focussed conversations with practitioners who were unable to attend. The review considered relevant information from parallel processes including the criminal investigation and family court proceedings and had planned engagement

[7] Child Safeguarding Practice Review Panel: practice Guidance (2019)

with the family. The Review Team provided oversight and challenge through their analysis of safeguarding practice.

2.8 The full Terms of Reference are included at Appendix A. Agencies were asked to submit information about their contact with the baby considering the following practice areas:

- Exploration of the wider family dynamics and parenting history
- Consideration of pre-birth assessment and post-natal support
- The extent of professional curiosity and challenge including opportunities for disclosure
- The system factors and decision making relevant to the referral to CASS
- What was the impact of service delivery on this family during Covid-19?

3. The Baby's Story

3.1 The baby lived in the maternal grandmother's home with the mother, maternal great-grandfather and maternal aunt. The mother had a history of anxiety and self-harm in the context of anxiety about her college work and a history of domestic abuse in a previous relationship. Their home was said to be cramped and 'cluttered' and needing repair.

3.2 Following the baby's birth in the midst of the first Covid lockdown, in May 2020, referrals were made by both BWH and WMP to CASS regarding domestic abuse when an incident of physical and coercive control towards the mother was witnessed outside the hospital. After screening the referral, CASS signposted the case to universal services for Early Help Assessment and the baby was discharged home in the care of the mother. After the baby's discharge there were routine visits by a Community Midwife and Health Visitor. The GP undertook a telephone consultation as mother raised concerns that the baby had a 'clicky' arm. The baby was taken to the Emergency Department who noted no concerns.

3.3 Two weeks later, the mother called an ambulance as the baby was suffering from abnormal breathing. On arrival at hospital the baby's condition deteriorated requiring the baby to be placed on a ventilator and sedated. Medical investigations revealed that the baby had suffered serious head injuries and bruising to the body. The medical view was that these injuries were likely to be non-accidental (inflicted), and possibly as a result of a shaking incident.

3.4 The hospital notified their concerns to Birmingham Children's Trust (BCT) and West Midlands Police (WMP) regarding the baby's presentation and joint section 47 enquiries commenced. WMP used their powers of police protection to ensure the baby remained in hospital and commenced a criminal investigation into how the injuries to the baby were sustained, and the parents were arrested.

Wider family dynamics and parenting history

3.5 The father was known to children's social care (CSC) and was in foster care as a child before he went to live with his paternal grandparents. He was diagnosed with Attention

Deficit Hyperactivity Disorder (ADHD), Autism and was recorded to have a learning disability[8] as a child related to specific problems in processing information, requiring additional support. He was known to have poor emotional regulation and experienced anger issues as a primary school aged child.

3.6 The father received clinical support from a multi-disciplinary team for these issues including therapy and medication. He was often supported by his grandfather at appointments and later as an adult he sometimes attended on his own. This information has been extracted from social care records and GP records although there is no further information around his diagnosis and additional support needs. The father spoke of his difficulties controlling his anger in his relationships and of his controlling behaviour. The information regarding possible indicators of abuse was not shared with other agencies. Although the father had care and support needs under the Care Act 2014 definition, he was not offered a referral to Birmingham Adult Social Care for a section 9 assessment [9] to consider how his needs impacted on his wellbeing.

3.7 The father had a known history of poor emotional regulation, propensity for anger and impulsivity which led to him coming to the attention of the Police on occasions and once led to his detention under Section 136, Mental Health Act 1983[10]. Prior to the period under review the father attended hospital on five occasions with hand injuries caused by punching objects or related to fighting. He was also known to the police for alleged domestic abuse.

3.8 The mother was known to universal services and had a history of low mood, previous self-harm and a previously violent relationship. There were also concerns regarding her home environment.

Timeline of key events related to serious incident

3.9 The following timeline sets out the key events in the baby's life from pregnancy until June 2020.

Date	Key Event
September 2019	The mother first attended for confirmation of her pregnancy with the baby. The father was noted as the father of the baby. The mother regularly attended maternity appointments with the father.
April 2020	The mother was asked about domestic abuse and none was disclosed.
May 2020	The baby was born.
13.05.2020	The mother and baby remained in hospital for medical care. When the mother informed the father, he was overheard by staff shouting at her on the phone and he was said to have texted her hundreds of times, demanding that the baby was brought outside or held up to the window.

[8] https://www.england.nhs.uk/wp-content/uploads/2020/01/Learning-disability-and-autism.pdf
[9] Care Act 2014 (legislation.gov.uk)
[10] https://www.legislation.gov.uk/ukpga/1983/20/section/136

Date	Key Event
13.05.2020	Police were called to the hospital as the father had been overheard threatening to smash his way into the hospital. The father was seen pinning the mother up against a wall outside the hospital. At that time visiting was restricted due to the COVID-19 pandemic.
14.05.2020	Referrals were made to CASS. The Police referral had incorrect information regarding the mother having children removed in another local authority area. The BCT CASS team screened the referral as 'complex and significant' based on this information and not based on the domestic abuse.
15.05.2020	During escalation of the referral by police and the MASH Safeguarding Nurse it was confirmed that the record of mother's previous children having been removed was an error (and related to a different family at the same address).
15.05.2020	The mother and baby were discharged home following advice from the Social Worker. The case was closed with outcome as Universal Plus.
16.05.2020	The Community Midwife visited the mother and baby at home and there were no documented concerns.
18.05.2020	The MASH Safeguarding Nurse emailed CASS to enquire following up the escalation of the professional difference in relation to the social care assessment, as they believed it should be Child Protection.
21.05.2020	Telephone new birth consultation by Health Visitor 1 (HV1) who was unaware of the notification from Birmingham Forward Steps (BFS) CASS in relation to the domestic abuse referral. During the call, the mother did not disclose any information regarding domestic abuse.
21.05.2020	The Community Midwife visited the mother and baby at home and there were no documented concerns.
22.05.2020	HV2 having been notified by HV1, liaised with the Community Midwife and GP to gain further information regarding the safeguarding referral.
26.05.2020	The Community Midwife visited the home and the mother expressed concerns regarding a 'clicky' arm when dressing the baby. Bruising from a medical procedure was noted on the baby's hand which was not previously recorded.
27.05.2020	GP made telephone contact regarding the baby's 'clicky' arm. GP advised a visit to A&E and registered the baby with the practice.
27.05.2020	At A&E the baby had full movement of their left forearm, their position and tone were normal, and the baby was discharged.
01.06.2020	Community Midwife visited the mother and baby at home. There were no concerns.
02.06.2020	HV2 attempted a telephone contact with the mother and was unable to leave a message so decided to visit unannounced.
02.06.2020	The GP wrote to the mother inviting the baby for the routine 6-8 week check.
03.06.2020	HV2 contacted the Community Midwife who told HV2 that the mother and father had a hostile relationship and "both can be to blame". The mother was staying at the maternal grandmother's house which was considered a protective factor.

Date	Key Event
04.06.2020	HV2 received information from CASS regarding the original referral made by the police. The referral had expressed concerns about the mother's partner being controlling of her.
08.06.2020	Planned booked clinic appointment was cancelled and a message was left by HV2 on the mother's phone.
09.06.2020	HV2 had a telephone contact with the mother, who both sounded and reported she was tired. The mother spoke briefly about the baby and that the feeds were going well. No other concerns were expressed.
09.06.2020	The father missed a further scheduled appointment with PN1 who had been providing support to the father for smoking cessation to be healthier for the baby
11.06.2020	HV2 undertook the home visit as planned; she planned to discuss domestic abuse and the mother's relationship with the father, but as he was present she was unable to ask. The baby was weighed and measured at the visit and further actions agreed.
13.06.2020	The baby was brought to BCH ED by ambulance with significant head injuries.

4. Analysis and findings

4.1 This review has explored the quality and effectiveness of the multi-agency safeguarding arrangements for new-born babies in Birmingham by reviewing six key practice episodes[11] (KPEIs). The following overarching research question was identified, with a particular focus on 'why' any practice deficits or errors occurred:

How assured are the safeguarding partners and relevant agencies that the multi-agency safeguarding system in Birmingham is effective in identifying and responding to new-born babies where there are known multiple parental vulnerabilities?

KPE1 – Opportunities for assessment in the pre-birth period and planning support for after birth

4.2 The mother first attended for antenatal care at her GP practice at five weeks gestation and was referred to midwifery services at age 19. Two weeks later she attended BWH Early Pregnancy Assessment Unit due to possible miscarriage and a viable pregnancy was confirmed. The mother subsequently attended for a dating scan.

4.3 The mother attended a routine booking appointment with the BWH Community Midwife, and an antenatal social risk assessment was completed. It was recognised that she was a pregnant teenager who disclosed low mood, some anxiety in relation to her college work and historic self-harm, but she did not feel that she would do it again and had seen her GP in relation to her mental health. However, the mother had not seen her GP for any mental health concern for two years. She declined referrals to perinatal

[11] Key episodes are periods of intervention that are deemed to be central to understanding of the agency involvement and work undertaken with the baby and the family.

mental health services as she said she had suitable support at home. The domestic abuse question was not asked as father was present. The father's neurodiversity diagnoses[12] were shared and documented in the maternity booking. The review team noted, as highlighted within '*The Myth of Invisible Men'* the focus of maternity booking is the mother, and the father was not a focus in terms of ascertaining any support for his ADHD and Autism and in becoming a new parent.

4.4 The Community Midwife reported they were unable to ask the routine domestic abuse enquiry as the mother was not seen alone. The local protocol is for the Community Midwife to ask to see the patient alone in these circumstances. The mother denied adverse childhood experiences (ACEs)[13]. She was assessed as '*Low Risk*' and suitable for Midwifery-led care. The father also attended, but his name was not recorded although it was documented that he had ADHD and 'slight' Autism Spectrum Disorder (ASD) [14], but no concerns were identified.

4.5 Father attended smoking cessation with PN1 at his GP Practice who reported that the father was "*excited about becoming a father and therefore wanting to give up smoking, also he was returning to work to keep busy*". PN1 knew the father well as he had attended the practice for fifteen years and as he was '*jovial' they* never discussed low mood. The father's GP records were not reviewed by PN1 although they contained indicators around his emotional dysregulation that had significance in terms of his potential parenting capacity as well as his own care and support needs. The father had previously not attended scheduled medical appointments and, as an adult with capacity, this was seen as his choice.

4.6 The mother attended all her maternity appointments, and her antenatal care was uneventful. Although living elsewhere the father regularly stayed overnight with the mother. The mother was not asked the routine enquiry domestic abuse question until 38 weeks gestation and said she felt safe at home and no domestic abuse was disclosed. The mother attended alone on three occasions, and it is not known why routine enquiry was not asked earlier. The baby was born eleven days later in BWH and the mother and baby needed to remain in hospital for continuing medical care.

4.7 The father's GP Practice did not know who the mother-to-be was and did not ask for her details as it was not routine practice to do so. The mother's GP knew of her pregnancy but had no details of the father nor his history and it is not expected practice to ask. This was seen by practitioners as a challenge for information sharing. The Community Midwife knew of the father's neurodiversity but did not explore how it impacted on his everyday life The planned health visiting antenatal contact would have been an opportunity to explore whole family preparedness for the baby.

4.8 While the mother's mental health and adverse childhood experiences were explored and documented, she declined further referral. The father's neurodiversity was not explored by the Community Midwife as to whether he was likely to bring positive

[12] Learning-disability-and-autism.pdf (england.nhs.uk)
[13] Adverse experiences in childhood | Local Government Association
[14] Attention Deficit Hyperactivity Disorder ADHD Foundation

parenting behaviours or if there were any vulnerabilities that required support. While it is recognised that not all parents with neurodiversity will require support, this needed to have been explored. Without this exploration it could not be known whether the mother and father required further support or would consent to an early help assessment, especially as the father had not received help for his neurodiversity for some time.

Key Practice Episode 1
Opportunities for assessment in the pre-birth period and planning support for after birth Birmingham Women's and Children's Hospital (BWCHT) agency report highlights their *Forward Thinking Birmingham* involvement saying, *there were a number of red flags within the FTB records that were predictors of the father's potential parenting capability and his need for ongoing support… his behaviour was escalating and despite contact... the father did not engage*. At that point there was no indication that he was to become a father. Following discharge from FTB this information was therefore held within his GP records, but he did not present at the surgery in a way that gave rise to concerns. As highlighted in *The Myth of Invisible Men* (2021)[15] '*Firstly, it is in the combination of factors… that risk occurs and secondly, the fact that too many men are not well engaged by services means that those risks go unidentified*'. There was significant information held within GP records and maternity records that could have highlighted the need for liaison and further assessment and support of the father. The information regarding possible risks and unmet need sat in his records and, as highlighted within the 'Myth of Invisible Men' 2021, the challenge is how this information is accessed when it is held in separate places and services are shaped to be focussed on the mother. In this case, the father had attended every maternity appointment with the mother prior to Covid and these aspects could have been explored with him and the mother and consideration given to maternity liaison, care or support needs and an Early Help Assessment. **Learning point 1:** Midwives should always fully document who attends at maternity booking appointments and create opportunities to see women on their own to make routine enquiries. Information was recorded around parental factors but not who the father was. All relevant parental information needs to be recorded, with a purpose of exploring what it means for the unborn baby and following birth. Further exploration around how the father experienced his neurodiversity, may have identified that he experienced emotional dysregulation, any known coping strategies and any additional supports required for himself as an adult with care and support needs who also has caring responsibilities. Preparation for fatherhood could have begun earlier with additional information provided to the mother and father such as the ICON[16] toolkit.

[15] The Myth of Invisible Men (publishing.service.gov.uk)
[16] About Icon | ICON (iconcope.org)

KPE 2 - Response to the domestic abuse incidents following the baby's birth

4.9 The first indication of possible domestic abuse by coercive control was following the baby's birth, for which the father had been present, when the mother informed the father of having to remain in hospital, and he was overheard shouting at her over the phone, although it was said to be difficult to work out exactly what he said. The mother appeared apologetic towards him, despite it being beyond her control that they needed to stay in hospital.

4.10 The next day BWH contacted WMP to report the concerns regarding the father's controlling and aggressive behaviour towards the mother. The father attended the hospital despite advice that he would not be allowed to enter due to the Covid-19 restrictions and was said to be angry he had not been allowed in to see the mother and baby. While there may have been an expected degree of frustration at this, the father's response was seen as disproportionate. Despite the mother recently having given birth and requiring treatment he was said to make demands on her that she could not fulfil. BWH staff reported they heard him say to the mother that if she did not bring the baby outside or get father into the ward to see the baby, he would fight his way into the hospital and assault people to achieve it. He was also heard to demand that she hold the baby up to a window so he could see the baby.

4.11 The mother went outside to see the father and staff at BWH witnessed him *'pin'* her up against a wall outside and appeared to grab her cheeks. This was out of view of hospital CCTV so BWH staff approached them and asked them to stay in view as the mother was still under hospital care and may need assistance. It was also noted on the ward that the father was sending '*hundreds of texts and calls'* to the mother who was said to have remained apologetic to him. The age differential between parents was also not considered in terms of the power and dynamics within their relationship.

4.12 Police officers dealing with the incident agreed that the BWH Safeguarding Midwife would talk to the mother to determine if she required referrals to be made and to offer safeguarding help due to domestic abuse or concerns regarding potential child abuse of the baby. WMP made a referral to CASS[17] and included information from the police system regarding the father previously being held under section 136, Mental Health Act 1983 after self-harming through punching solid objects, and concerns about domestic abuse in his previous relationships.

4.13 WMP officers decided a *Domestic abuse frontline risk assessment* (DARA)[18] could not be completed in person while she was on the ward. A risk assessment of '*medium*' was recorded based on the details provided by the hospital and given that the mother had recently given birth, which was seen as appropriate.

[17] Refer a child who you're concerned about (birminghamchildrenstrust.co.uk)
[18] DA_risk_assessment_pilot.pdf (college.police.uk)

4.14 While WMP provided CASS with the available information regarding the father's history incorrect information regarding the mother's history was also included in the Police referral to CASS. This stated that she had previously had four children removed in another authority. This was inaccurate and related to a different family, and was noted to be implausible given her age, however, it became a focus of the CASS consideration of the referral. Due to WMP's concerns regarding the imminent discharge of the mother and baby from BWH, and the concerns regarding domestic abuse the officer made a call to CASS. They were informed the referral would be brought to the attention of the CASS manager, due to the concerns regarding children previously being removed, and due to the possible hospital release date planned the next day.

4.15 The Safeguarding Midwife at BWH asked the Ward Midwife to make enquiry with the mother regarding possible domestic abuse. The mother was spoken to regarding the concerns for the baby's and her safety, but she denied that there was any domestic abuse. She disclosed that she had suffered emotional abuse, while still a child herself, from her previous partner who had become violent towards the end of their relationship.

4.16 The Ward Midwife telephoned the Community Midwife to seek her view of the parental relationship. The Community Midwife advised that prior to COVID-19 restrictions, the father had attended all appointments with the mother. The mother said the relationship between the baby's father and her own mum could be difficult but that she felt they had got on better since her pregnancy due to having something to bond over. The Community Midwife reported that the father had telephoned her a few times during the pregnancy to ask questions and had called that day to ask if the mother and baby could stay at his house overnight. While she felt '*there was something about the father that she couldn't put her finger on*' she was aware that he had ADHD and ASD. She had noted that the father had the mother's phone during appointments. The Community Midwife noted that the father had repeatedly questioned the mother during the pregnancy, but while unusual and possibly due to his neurodiversity, the Community Midwife did not view it as an abusive relationship.

4.17 The Ward Midwife spoke with the BWH Safeguarding Midwife who spoke to CASS regarding the evidence suggestive of domestic abuse and that coercive control had been seen by health staff at the hospital postnatally. Also, there were concerns regarding the inherent vulnerability for the baby, being new-born, and the known increased risk of domestic abuse following the birth of a baby[19]. Information regarding the father's ADHD and ASD was not shared as that was in the Community Midwife's record. The BWH Safeguarding Midwife reiterated their view that due to the concerns of risk of domestic abuse that child protection enquiries should be made. It would have also been helpful to seek a discharge planning meeting as part of any strategy discussion.

4.18 The Ward Midwife completed a DASH[20] form which was scored at '1', and *'low risk'* due to the mother's denials of any abuse having occurred. CASS advised BWH that a Social

[19] Risk factors | Background information | Domestic violence and abuse | CKS | NICE
[20] Dash without guidance.pdf (safelives.org.uk)

Worker had been allocated and that she had been made aware of the police information regarding the mother. The Social Worker was completing an assessment and following lateral checks, reported there were no records of the mother being known to CSC in Birmingham or neighbouring local authorities.

Key Practice Episode 2
Response to the domestic abuse incidents following the baby's birth While the DASH form had been scored by BWH according to the mother's negative responses, the CASS referral included the known coercive control and use of physical force by the father to push the mother against the side of the building, which had been observed by staff. It was noted within the reflective learning event that expected practice would be for the *Specialist Midwife Domestic Abuse* to review the DASH form scoring and take the case to a *Multi-Agency Risk Assessment Conference* (MARAC)[21] for further consideration of supports and interventions required. Assurance has been provided regarding the work ongoing within BWH regarding the quality of referrals to CASS. It should be noted that the response to the domestic abuse incidents was timely and there was exploration with the mother regarding her possible experiences of domestic abuse. While she did not appear aware that the relationship dynamic was abusive the hospital were clear about the risks. **Learning point 2:** There is a need for all practitioners to complete the DASH form according to the DASH guidance so that denials of domestic abuse do not result in a *'low risk'* outcome especially where coercive control and physical force has been witnessed by professionals.

KPE 3 - Effectiveness of the initial response to domestic abuse and strategy planning

4.19 The Police referral was screened the following day by a Senior Practitioner. Due to the concerns regarding four children being removed and '*domestic abuse in pregnancy*', it was decided under the '*Right Help, Right Time (2020)*'[22] threshold document, the concerns were '*complex and significant*' and further social work oversight was required. Although it was clear that the baby had been born, the outcome was "*Pre-birth assessment[23] required.*" The actions noted were contact was required with the parents to seek consent for information sharing, and to check with the other local authority regarding other children previously having been removed.

4.20 When discussed with the CASS Practice Supervisor during a focussed conversation, they advised they were unclear why a pre-birth assessment was recommended, as the baby had already been born. It is noted that a single assessment at that point would have provided an opportunity to analyse the potential risk to the baby and whether the mother and father were likely to require support to parent the baby safely.

4.21 WMP confirmed to the BWH Safeguarding Team that the safeguarding information seen on the Police National Computer records was not related to the mother but a

[21] MARAC- Safeguarding Professionals | West Midlands Police (west-midlands.police.uk)
[22] Right_Help_Right_Time_Guidance_Feb_2020.pdf (lscpbirmingham.org.uk)
[23] Pre-Birth (proceduresonline.com)

historic issue at the address. The safeguarding midwife then contacted CASS who confirmed they were aware of the inaccurate information which was confirmed on lateral checks. The lateral checks did not extend to the GP for either parent. This was noted as an issue as CASS workers did not have easy access to GP information and they therefore sought health information from the referrer.

4.22 The following day the Police Officer and the Social Worker discussed the incorrect information. The Social Worker had spoken to the mother on the telephone who said she had never had any children removed and this was probably an untrue allegation by the father's ex-partner. The mother again denied any abuse in their relationship. This prompted a discussion between Police and the Social Worker who agreed *for a S17 assessment to take place.*

4.23 As highlighted within the *BCT Information Report* this was despite the fact that, '*hospital staff had witnessed concerning and controlling and threatening behaviour by the father towards the mother, by making demands that she was unable to comply with, threatening her by backing her up to a wall and pinching her cheeks as part of threatening behaviour'*. Despite an earlier escalation by the BCHC Safeguarding Nurse, the response by CASS to the escalation was insufficient as there was no strategy discussion held, and the Safeguarding Nurse was not involved in decision making and they were informed by email later.

4.24 From the focussed conversation held with CASS staff the practitioner recalled the mother denied any domestic abuse and having discounted the incorrect information this provided reassurance that the case did not need to be passed to ASTI for a section 17 assessment. The case was referred for Early Help, Universal Plus. CASS had missed the parental factors within the Police referral and no contact had been made with the father of the baby to explore his behaviour at the hospital with the mother.

4.25 Within the focussed conversation with CASS staff it was recognised that having discounted the incorrect information the case was not reframed around risk of harm due to possible domestic abuse based on observed behaviours at the hospital. This does not explain why there was no discharge planning meeting for the mother and baby give the open escalation.

4.26 Once this information was confirmed to be incorrect to the hospital staff it shifted the focus on when to discharge the mother and baby. Had the escalation succeeded and further lateral checks been made in MASH, including to the father's GP, these checks could have revealed his history of poor emotional regulation, propensity to anger, adverse childhood experiences and lack of engagement with mental health services. This information may have further indicated that a strategy discussion and discharge planning with a safety plan was required.

4.27 Within the reflective practitioner event it was noted that the baby would be going home with the mother to the maternal grandmother's home. The home conditions and adults there were unassessed, yet this was recorded in the assessment as being a

protective factor. It is unclear on what basis this assessment was made as there had been no assessment by the Police or CASS of the other adults living in the home.

4.28 Once the CASS screening had taken place the CASS Team Manager reviewed and reassigned the referral, and this included the manager's rationale and decision in agreement with the Social Worker. In the reflective discussion the Practice Supervisor said that their own practice is to pass cases through for further assessment "*if they are 90% sure MASH or ASTI involvement is required*" which they felt this case required. However, having discounted the incorrect information regarding children previously being removed, the focus of the referral around risk of domestic abuse post birth was downgraded and the case was stepped down.

Key Practice Episode 3
Effectiveness of the initial response to domestic abuse and strategy planning There was no proper assessment as to whether there was a risk of physical harm to the baby based on the additional factors included in the referral about previous domestic violence complaints against the father and of emotional dysregulation and impulsivity. The CASS assessment did not explore these issues nor discuss the father's needs with any agency or speak to him. This is important because full checks were not made, and as highlighted in the *BCT Information Report* '*The rationale recorded stated that "Health checks confirm they do not have any concerns noted on their system." This was not the case as Health had provided a detailed account of their concerns at referral*.' This statement refers to the referral from Birmingham Women's and Children's NHS Trust and escalation by the Named Children's Safeguarding Nurse. The Social Workers and ward staff were reassured that it was safe to discharge the baby and progress as Universal Plus, despite no assessment of the other multiple parental risk factors in the referral and the incident being witnessed by staff. The BCT agency report determined this was based on the fact that previous children had not been removed from the mother's care and the other factors of concern became secondary. The case was closed to CASS and a Birmingham Forward Steps (BFS) CASS notification was sent to Birmingham Community Healthcare Trust (BCHC) Health Visitor *'to lead on Early Help Assessment and family support to offer support with domestic abuse and impact on mother's wellbeing and new-born bab*y'. This decision was not challenged by the practitioners working with the family and was not notified to the parents' GPs who remained unaware of the safeguarding concerns. The CASS and MASH processes received positive feedback within Ofsted visits. However, CASS staff reported that a high volume of referrals and lack of capacity, was a system factor that had impacted on their response with this family. The team felt that there was not always enough time to complete full assessments and make all lateral checks before a decision needed to be made. In June 2020 there was a lack of multi-agency staff and this was improved as Birmingham Children's Trust, health agencies, probation and education increased their capacity at the front door. The CASS staff also advised that there were sometimes errors in information provided in referrals from WMP which, although usually

Key Practice Episode 3
quickly corrected, had also influenced their thinking. The CASS staff demonstrated a good understanding that the framing of the case around children previously being removed had resulted in an incorrect threshold decision being made. System factors identified included that: a) By allowing the framing of the referral to become fixed around previous removal of the children this impaired objectivity in the response with this family. This can be seen as '*confirmation bias'* where '*once we have formed a picture of a person or family, we have a strong tendency to keep to it*'[24]. There was also confirmation bias in that the practitioners accepted assurances from the mother regarding domestic abuse and also her explanation of an untrue allegation. Practitioners and managers need to maintain objectivity and ensure assessments evaluate all known factors before threshold decisions are made. It also needs to be recognised that where practitioners' perception is of volume overload that this can lead to less reflection and poorer decision making. b) Lateral checks are not made to GPs at CASS level and CASS rely on health information provided within the referral. This means there can be gaps in the information when referrals are screened by CASS. c) Incorrect information in referrals can contribute to practice errors. The partnership needs to be assured of the impact on practice of these system issues and whether there is typicality in the outcomes found in this case. **Learning Point 3:** There were practice errors in the decision-making within CASS screening. It was not recognised that the presenting concerns were risks from domestic abuse as an assault was witnessed immediately following birth. The assessment did not include parental history factors and discounted concerns highlighted in the referral. The initial decision for a section 47 was downgraded to a single assessment without consideration of the wider family situation including both parents' histories and parental risk or vulnerability factors, their possible impact on parenting capability and possible risks to a vulnerable baby. Then, although a single assessment was agreed by the practice supervisor, the case was closed and signposted to Universal plus. Practitioners need to be able to respond to and act on clear evidence of domestic violence and abuse, which in this case was clearly witnessed by staff. It is important to consider how practitioners could have considered the mother's denials and provided challenge and opportunities for disclosure.

KPE 4 - Effectiveness of attempts at escalation and professional challenge

4.29 The WMP investigation log recorded a number of calls between social services and the safeguarding team at BWH and that a DASH had been completed by BWH staff and '*all questions were answered no'*. BCT MASH staff recorded the matter would proceed to

[24] Munro, E., Guide to analytic and intuitive reasoning, 2009

a *Section 17*[25] social work assessment in relation to the baby and the police would be contacted if there were further concerns or disclosures during this assessment.

4.30 Both the BCHC Safeguarding Nurse and Police Officer working in MASH believed there should be a strategy discussion as the baby was '*at risk of suffering significant harm*.' It was also noted that given the mother's age it was extremely unlikely she had previously had four previous children removed and their concerns were around *'domestic abuse in pregnancy.'* They remained concerned that CASS had made a decision that a '*Section 17 assessment'* (Child in Need) would be sufficient. Due to the difference of opinion between the Safeguarding Nurse and Police and the CASS referral outcome, the BCHC Safeguarding Nurse escalated this within the CASS process. Had the case escalated to the MASH, full health checks would have been completed.

4.31 The Community Midwife visited the mother and baby at home the following day and there were no documented concerns. The MASH Safeguarding Nurse emailed CASS to request an update following the escalation. This enquiry was responded to by email three days later giving the social work rationale for decision-making from Complex and Significant to Universal Plus. The BCHC agency report highlighted, *'although the concerns were escalated in line with the CASS process, the Safeguarding Midwife was not able to get the outcome in a timely manner'.* This was escalated to her manager and discussed at the MASH Leads Escalation Meeting, although the outcome is not recorded. There is no evidence of further escalation of this decision under the BSCP Escalation Policy[26].

Key Practice Episode 4
Effectiveness of attempts at escalation and professional challenge There was evidence of professional challenge around the risks of domestic abuse by BCHC and WMP and to seek progression of the referral through to the MASH. However, professional concern did not extend beyond the first stage and attempts at professional resolution and escalation stalled. Indicators of coercive control, and hostility in the relationship between the parents and within the father's other relationships were reported by the Community Midwife to the Health Visitor following the witnessed incident at the hospital, which could have been shared. The father's neurodiversity was known, but not how it might affect his functioning within relationships. Previous experience of domestic abuse can also be a factor in understanding healthy relationships. All staff did not perceive the threshold for intervention was met until the witnessed incident. Once this was recognised the escalation protocol was initiated but did not progress through the staged approach. **Learning point 4:** The threshold for '*complex and significant'* was met due to '*Domestic abuse/coercive control, including in pregnancy*'. A strategy meeting could have discussed discharge planning and refocused thinking, allowing the risks to be considered more robustly and for formal escalation to take place when the agreed section 47 did not take place. Where

[25] 1.18 Additional guidance | West Midlands Safeguarding Children Group (procedures.org.uk)
[26] 1. Escalation Policy Flowchart (procedures.org.uk)

application of thresholds is not in line with Right Help, Right Time (2020), escalation needs to follow the agreed protocol including exploration with agency named safeguarding leads.

KPE 5 - Effectiveness of early help assessment and response to domestic abuse following discharge

4.32 The mother and baby were discharged to the maternal grandmother's address the same day. Following discussions with the Social Worker and the Community Midwife it was agreed to continue with advice and support and observe the family at home. The Maternity Liaison form was completed the same day and sent to the Health Visitor sharing the concerns while in the hospital but was not received until a week later. The GP received the neonatal discharge letter from the hospital which showed that discharge had *'been agreed with Social Services'* but there is no record of them receiving the Maternity Liaison form. This is important as the GP did not know about the safeguarding concerns and had they been alerted they could have exercised more professional curiosity by enquiring why the discharge of the baby needed agreement by CSC.

4.33 The Health Visiting Duty Team received the referral outcome recommending the Health Visitor completes a new birth visit and attempts to see the mother and baby to safely ask about domestic abuse. However, the new birth contact had already taken place via telephone as HV1 was unaware of the notification from CASS in relation to the domestic abuse incident at BWH.

4.34 During the consultation, the mother did not disclose any domestic abuse and HV1 was unable to ask the routine domestic abuse question as they heard family members in the background. The BCHC agency report suggested consideration needed to be given about how to create an opportunity to see the mother on her own. HV1 changed the Health Visiting dependency level from Universal to Universal Plus Medium and the case was picked up by HV2.

4.35 The following week liaison took place between HV2, the Community Midwife and the GP Practice to ensure the safeguarding information was correct and to gain further information. The CASS recommendation was for the '*Health visitor to lead on EHA and family support to offer support with domestic abuse and impact on mother's well-being and new-born baby',* to signpost the mother to domestic abuse services and '*explore with parent re: history of previous children being removed*'. This was confusing as CASS had already been assured that the information was incorrect. HV2 therefore was to focus on domestic abuse within the Early Help Assessment and to update BFS CASS in 4 weeks.

4.36 When the baby was two weeks old the Community Midwife visited the mother and baby at home. Grandmother reported hearing a 'click' around the arm area when dressing the baby. There were no visible marks or any discomfort noted when checked. The mother was advised by the Community Midwife to see the GP. The Community Midwife recorded there was slight bruising from a cannula site (medical procedure) on the baby's hand.

4.37 Under Covid-19 arrangements the GP had a telephone consultation regarding the mother's concerns that the baby had a '*clicky*' arm and enquired whether any injury had occurred or any history of a traumatic birth, and as none was reported the mother was advised to go to the Emergency Department (ED).

4.38 At the ED, the mother advised that since the Community Midwife's examination of the arm the baby appeared to be in more pain and crying. The baby was observed as otherwise well and was reported to be feeding well. The baby had full movement in the left forearm, with position and movement identical to the right side. The baby was discharged home with mother, no safeguarding concerns were raised, and mother was advised to return if she had any further concerns.

4.39 It was noted in the reflective learning event that without the earlier context of concerns that ED staff at BCH would not necessarily have been concerned about risk of inflicted injury to the baby. It was noted that staff were reassured that the baby had been bought into ED by their parent straight away, despite safeguarding child practice reviews highlighting parents have also sought help soon after injuring their baby.

4.40 The Community Midwife visited the home four days later and mother informed that there were no concerns following the visit to ED, there was no noise heard during examination and the baby had good arm movement. The mother and baby were discharged from Maternity Services and care was handed over to HV2.

4.41 HV2 attempted telephone contact with the mother but was unable to leave a message, so planned an unannounced visit in next 24 hours. The next day HV2 contacted the Community Midwife who again confirmed the information regarding the removal of children was incorrect. The BCHC records state that the Community Midwife advised that parents '*had a hostile relationship and "both can be to blame"'.* She reported seeing the mother in the home environment, that the father had been staying there for support but she had not seen the mother on her own due to size of the property. Also, the mother was staying at maternal grandmother's house which was considered to be a protective factor; albeit this was unassessed and it is unclear what evidence they had seen to support this view.

4.42 HV2 decided to complete a home visit within 24 hours to review the family home as the Community Midwife indicated the home conditions were cramped and '*cluttered*'. HV2 telephoned the mother the same day and she reported the baby was well. Instead of the planned home visit HV2 agreed with the mother for her to attend Well Baby Clinic the following week.

4.43 The planned clinic appointment did not take place due to HV2 having unforeseen car problems, and the appointment was cancelled with a voicemail left for the mother. The following day HV2 called the mother and noted her voice appeared tired which mother confirmed. The mother spoke briefly that the baby was feeding well, and she had no other concerns. A home visit was booked for two days' time.

4.44 HV2 undertook the home visit with the mother and father, grandmother and maternal aunt. It was noted the baby's head circumference had increased by three centiles, although it appeared in proportion to the body. It had increased enough to make a note on the records and to plan to discuss it with the GP on their next working day. The baby was observed to be well, alert, active and of good skin tone. The home conditions were noted to be poor with exposed concrete blocks and the corridor was packed with baby toys and *'clutter of items'*. HV2 was unaware of a previous anonymous referral to CASS in 2018 regarding rubbish in the property which was referred to the housing department.

4.45 Two days later the baby was admitted to hospital by ambulance and found to have a significant head injury, bruising to the leg and mid-abdomen said to be indicative of a non-accidental (inflicted) injury. Appropriate actions were taken to safeguard the baby and the parents were arrested.

Key Practice Episode 5
Effectiveness of early help assessment and response to domestic abuse following discharge The delay in information sharing between maternity services and health visiting services did not appear to impact on the services provided to the family as the new birth contact was made in a timely way. HV1 received the CASS outcome form so reviewed the baby's records and changed the Health Visiting dependency level from Universal to Universal Plus Medium. There was immediate liaison between the Community Midwife and HV2. The review noted that delaying the planned home visit and waiting a further 11 days to see the mother to explore the domestic abuse concerns was not in line with best practice and guidance. CASS expected an update from the Health Visitor Team within 4 weeks of the referral. Arranging to see the mother in the clinic would have exceeded the time limit possibly by an extra 1-2 weeks. The BCHC agency report noted, '*due to the change of practice amid Covid-19 pandemic, HV2 should have contacted her manager or the BCHC Safeguarding Team to discuss further opportunities or ways available to explore domestic abuse with the mother in private'*. There was no record of the GP being updated regarding the lack of opportunity to explore the domestic abuse. The delayed visits to home or clinic meant the Early Help Assessment had not been undertaken at the point of the injury to the baby. **Learning Point 5:** There were gaps in the information available to all professionals which meant practitioners did not have the full history of concerns around domestic abuse, the father's history of behaviour in relationships, impulsivity, poor anger management and mental health problems. This impacted on the conduct of the early help assessment, decision making and limited opportunities to explore how the mother and father were managing as first-time parents and consider risk factors such as domestic abuse and previously unknown substance misuse which father advised his GP of after the injuries came to light.

4.46 Within the reflective learning event the GP highlighted they were unaware of the domestic abuse at the hospital although they had received documentation that the discharge had been agreed with CSC. Had they received information through lateral

checks or safeguarding notes, they may have contacted CASS themselves and arranged a face-to-face appointment regarding the baby's 'clicky' arm. In any case it would have been best practice for the GP to have spoken to the consultant paediatrician at the hospital.

4.47 It was recognised at the reflective learning event that it had been positive practice by HV2 to measure head circumference as this was outside of expected practice locally. The GP advised it was a significant increase of three centiles from the 50th to 98th centile line. While it is important to ensure there is no hindsight bias in the findings, it was noted that this change may have benefited from an urgent discussion with the GP. The GP advised an increase of head size by three centiles would require contact with the on call paediatric registrar to discuss possible admission to hospital to consider medical or other causes. However, this information was not shared with the GP in a timely way.

5. Contextual information

What was the impact of service delivery on this family during Covid-19?

5.1 Covid-19 Pandemic and the national lockdown from 23 March 2020 impacted on the face-to-face delivery of services to children and families. The partnership responded quickly establishing the Partnership Operational Group to oversee the City's safeguarding partnership response to the pandemic whilst ensuring compliance with changes in national guidance.

5.2 Much of the mother's maternity and postnatal care took place during the Covid-19 pandemic. Although the partnership responded swiftly to ensure Covid-19 working arrangements were addressing any possible safeguarding issues in service delivery, there are several points where this was impacted. The first practice point was during the mother's pregnancy, as she was not visited at home by the community midwife[27], although a visit had been planned and a telephone call was made at 36 weeks + 4 days. As there were other people heard on the call the routine question regarding domestic abuse was not asked.

5.3 When the mother had to stay in hospital with the baby due to Covid-19 Regulations, the father was not allowed to remain in the hospital. Outside of Covid-19 arrangements, it would have been routine practice to allow visits to the ward, this would have allowed staff to monitor and assess the parental interactions as well as for police to speak to the parent's about the witnessed domestic abuse incident. While the father's emotional reaction to not being allowed into the hospital to visit the baby and the mother was seen as disproportionate and irrational it was not evident that the reasons for his reaction were explored. This could have been an opportunity to consider how he coped with new or stressful situations, such as looking after a newborn

[27] home-visit-guidance-for-midwives.pdf (rcm.org.uk)

baby, and an opportunity to review how his neurodiversity may affect his responses and what support he may require[28].

5.4 Hospital and police staff may have been able to speak to the mother and father in person outside of the Covid-19 arrangements and to seek to provide support to the father to help him better manage his emotional responses. It is debatable as to whether this would have made any difference to his behaviour at the time. Although different supports may have been offered to him and the mother within a 'Think Family' approach.

6. Conclusion

6.1 This review has examined the contact and involvement of a number of agencies involved with the baby and the family and sought to answer the research question posed. The review has identified some gaps in practice and systems issues around multi-agency assessments. These impacted on the effectiveness of the multiagency response to safeguard vulnerable babies whose parents have multiple vulnerabilities and who may have care and support needs requiring assessment and provision of services in their own right.

6.2 Exploration of this may not have led to any disclosure, but without professional curiosity and challenge around the identified parental risk factors it could not be known whether the mother and father were coping well, or if there were unmet needs or risks to the baby that required an Early Help Assessment, support through adult mental health services, or a safeguarding referral to CASS. At no point were the care and support needs of the father considered for assessment under the Care Act 2014, nor were there sufficient concerns identified to refer to BCT during pregnancy.

6.3 The lack of patient record integration across the health service is a known barrier nationally to information sharing, especially where parents attend different GP practices, and highlighted in the *Myth of Invisible Men (2021)*. Where a GP becomes aware of an impending fatherhood, and there are known indicators of risks to the mother and unborn within the father's medical records such as the previous history of hand injuries when dysregulated, detention under section 136 Mental Health Act and coercive control, the GP should seek support through the Birmingham ICB safeguarding duty line and fulfil their responsibility to share the relevant information. There is currently no expectation for GPs to gather information regarding a prospective mother in these circumstances. There is also no method, nationally, to link records when they are held in different GP practices.

6.4 The review found that both parents, to differing extents, had suffered from Adverse Childhood Experiences. Research tells us that, '*Young people who have been exposed to trauma are more likely to have psychological and behavioural problems, and there is evidence that greater trauma exposure is associated with more severe and diverse*

[28] Coronavirus » Managing demand and capacity across MH and LD – Nov 2020 (england.nhs.uk)

behaviour problems'[29]. The approach to assessment and analysis would have benefited from further exploration and triangulation of these elements and how they might impact on the mother and father's parenting ability as relatively young, new parents.

6.5 The review found that human factors around '*confirmation b*ias' hindered the judgements made and actions taken. The application of thresholds, decision-making and levels of support offered to the baby and the parents around known factors such as low mood, poor emotional regulation, learning disability and neurodiversity were not consistent with the level of possible risk or unmet need. The practitioners' responses were influenced by acceptance of the parents' assurances around concerns raised.

6.6 The review identified a number of system factors that impacted on the response to the referral to CASS. The BSCP has a robust, well-defined escalation protocol that practitioners were aware of but attempts to escalate this case stalled and professional differences were still unresolved when the baby was injured. This cannot be said to have made a difference to the outcome for the baby, but the case might have entered section 47 enquiries if the professional disagreement around thresholds had been resolved.

6.7 During the review practitioners raised concerns regarding the volume of referrals into CASS and their capacity to progress them robustly in a timely way. Assurances have been provided to the review that caseloads are regularly reviewed, and the CASS processes had been strengthened following their Ofsted focussed visit, February 2020 and reinspected as part of the full ILACS Inspection in February 2023[30].

6.8 There were gaps in the information known by practitioners responsible for the baby's care. Relevant parental information was included in the referrals to CASS, but their screening process did not include lateral checks to GPs who held the detail of the concerns. However, there is a developing piece of work around Shared Care Records designed to strengthen health information sharing in MASH (and MARAC and MAPPA). There were also practice issues due to Covid-19 visiting restrictions both at the hospital and at home.

6.9 The identified practice and system improvements that may be required are outlined in the Executive Summary at paragraph *1.166..*

[29] (Lansford et al., 2012; Greeson et al., 2014).
[30] https://files.ofsted.gov.uk/v1/file/50214110

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Glossary of Agencies and Terms

Abbreviation	Meaning
ACE	Adverse childhood experiences
ADHD	Attention Deficit Hyperactivity Disorder
ASTI	Assessment and Short Term Intervention Service
BCH	Birmingham Children's Hospital
BCHC	Birmingham Community Healthcare NHS Foundation Trust
BCT	Birmingham Children's Trust
BFS	Birmingham Forward Steps
BSCP	Birmingham Safeguarding Children Partnership
BWCH	Birmingham Women and Children's Hospital Trust
BWH	Birmingham Women's Hospital
CASS	Children's Advice and Support Service
CiN	Child in Need assessment or plan under section 17 Children Act 1989
CPP	Child Protection Plan following section 47 enquiries (Children Act 1989)
CSC	Children's Social Care
EHA	Early Help Assessment
FTB	Forward Thinking Birmingham (Mental health services 0-25 years)
GP	General Practitioner
HV	Health Visitor
ILACS	Inspection of local authority children's services
LCSPR	Local Child Safeguarding Practice Review
MASH	Multi-Agency Safeguarding Hub
NICE	National Institute for Health and Care Excellence
NSPCC	National Society for the Prevention of Cruelty to Children
PN	Practice Nurse
TAF	Team around the Family
WMP	West Midlands Police

Appendix A – Review Terms of Reference

Overarching Review Question:

How assured are the safeguarding partners and relevant agencies that the multi-agency safeguarding system in Birmingham is effective in identifying and responding to new-born babies where there are known multiple parental vulnerabilities?

Key lines of enquiry:

Key lines of enquiry were also identified from the rapid review for consideration and analysis, with a particular focus on 'why' any practice deficits or errors occurred:

- How did professionals explore and understand the wider family dynamics, consider pre-birth assessment during antenatal care and during postnatal care following the baby's birth?
- Did professionals make assumptions that, given that the mother was living in an extended household with her own mother, the other household members would be a protective factor?
- Explore the extent of professional curiosity and challenge, particularly when the mother didn't take the opportunity to disclose domestic abuse, although this was witnessed by professionals in a health care setting.
- How did professionals try to create a 'safe' environment to provide an opportunity for the mother to make a disclosure?
- What did agencies know about mother and father's backgrounds, e.g. ADHD, Adverse Childhood Experiences (ACEs), impulsivity, anger management, mental health, domestic abuse, substance and alcohol misuse?
    - If these issues were identified, was it considered in parenting assessments and plans?
    - Are professionals aware of the effects of these factors and how it could affect parenting capability?
- What was the impact of service delivery on this family during Covid-19?
- When the referral in May 2020 was escalated by the MASH Safeguarding Nurse, was the action taken by Birmingham Children's Trust sufficient, and was the outcome communicated? What was the rationale for changing the decision from recommending an assessment to stepping down to Early Help?
- What impact did the delay in sharing information between the Maternity Service and Health Visiting Service have on the actions taken by the Health Visitor and the services provided to the family?